Influenza-Associated Pediatric Deaths Case Report Form

STATE USE ONLY – DO NOT SEND INFORMATION *IN THIS SECTION* TO CDC		
Last Name: ______________________	First Name: ______________	County: ______________
Address:	City:	State, Zip:

Patient Demographics

1. State:	2. County:	3. State ID:	4. CDC ID:
5. Age: _____ ☐Days ☐Months ☐ Years	6. Date of birth: _______/ _______/ ________ MM DD YYYY	7.Sex: ☐ Male ☐ Female	8. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

9. Race: ☐ White ☐Black ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐American Indian or Alaska Native ☐Unknown

Death Information

10. Date of illness onset: _______/ _______/ _______ MM DD YYYY	11. Date of death: _______/ _______/ _______ MM DD YYYY	12. Was an autopsy performed? ☐Yes ☐No

13. Location of death: ☐Home ☐Emergency Dept (ER) ☐Inpatient ward ☐ICU ☐Other (specify): ________________________

Influenza Testing (check all that were used)

Test Type	**Result**	**Specimen Collection Date**
☐Commercial rapid diagnostic test	☐Influenza A ☐Influenza B ☐Negative ☐Influenza A/B (Not Distinguished)	_____/ _____/ _____
☐Viral culture	☐Influenza A (Subtyping Not Done) ☐Influenza B ☐Negative ☐Influenza A (Unable To Subtype) ☐Influenza A (H1) ☐Influenza A (H3)	_____/ _____/ _____
☐Direct fluorescent antibody (DFA)	☐Influenza A ☐Influenza B ☐Negative ☐Influenza A/B	_____/ _____/ _____
☐Indirect fluorescent antibody (IFA)	☐Influenza A ☐Influenza B ☐Negative ☐Influenza A/B	_____/ _____/ _____
☐Enzyme immunoassay (EIA)	☐Influenza A (Subtyping Not Done) ☐Influenza B ☐Negative ☐Influenza A (Unable To Subtype) ☐Influenza A (H1) ☐Influenza A (H3)	_____/ _____/ _____
☐RT-PCR	☐Influenza A (Subtyping Not Done) ☐Influenza B ☐Negative ☐Influenza A (Unable To Subtype) ☐Influenza A (H1) ☐Influenza A (H3)	_____/ _____/ _____
☐Immunohistochemistry (IHC)	☐Influenza A ☐Influenza B ☐Negative	_____/ _____/ _____

Culture confirmation of INVASIVE bacterial pathogens

14. Was an INVASIVE bacterial infection confirmed by culturing an organism from a specimen collected from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)? ☐Yes ☐No

☐*Streptococcus pneumoniae*	☐*Staphylococcus aureus,* methicillin **sensitive**	☐*Neisseria meningitidis (serogroup, if known):*_______
☐*Haemophilus influenzae* type b	☐*Staphylococcus aureus,* methicillin **resistant (MRSA)**	☐Group A streptococcus
☐*Haemophilus influenzae* not-type b	☐*Staphylococcus aureus,* **sensitivity not done**	☐Other invasive bacteria: ________________________

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Medical Care 15. Did the patient receive medical care for this illness? ☐Yes* ☐No
16. **If YES*,** indicate level(s) of care received (check all that apply): ☐Outpatient clinic ☐ER ☐Inpatient ward ☐ICU
17. Did the patient require mechanical ventilation? ☐Yes ☐No

Clinical Diagnoses and Complications
18. **Check all complications that occurred during the acute illness:** ☐**NONE** ☐Pneumonia (Chest X-Ray confirmed) ☐ Acute Respiratory Disease Syndrome (ARDS) ☐Croup ☐Seizures ☐Bronchiolitis ☐Encephalopathy/encephalitis ☐Reye syndrome ☐Shock
☐Another viral co-infection: ____________________________ ☐ Other: ____
19. **Check all medical conditions that existed before the start of the acute illness:** ☐**NONE** ☐Moderate to severe developmental delay ☐Hemag-lobinopathy (e.g. sickle cell disease) ☐Asthma/ reactive airway disease ☐Diabetes mellitus ☐History of febrile seizures ☐Seizure disorder ☐Cystic fibrosis ☐Cardiac disease (specify) ______________________________________
☐Renal disease (specify) ___________________________________ ☐ Chronic pulmonary disease (specify) _____________________________
☐Immunosuppressive condition (specify) _____________________ ☐Metabolic disorder (specify)
☐Neuromuscular disorder (including cerebral palsy) (specify) ☐Pregnant (specify gestational age) _______ weeks
☐Other (specify) ____

Medication and Therapy History
20. Was the patient receiving any of the following therapies prior to illness onset? **(check all that apply)** ☐Aspirin or aspirin-containing products ☐Steroids taken by mouth or injection ☐Chemotherapy treatment for cancer ☐Radiation therapy ☐Any other immunosuppressive therapy:

Influenza vaccine history
21. Did the patient receive any influenza vaccine during the current season (before illness) ☐Yes* ☐No
22. **If YES*,** please specify influenza vaccine received before illness onset: ☐Trivalent inactivated influenza vaccine (TIV) *[injected]* ☐Live-attenuated influenza vaccine (LAIV) *[nasal spray]*
23. **If YES***, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)
☐1 dose **ONLY** ☐<14 days prior to illness onset ☐>14 days prior to illness onset Date dose given:_______/ _______/ ______ MM DD YYYY
☐2 doses ☐2nd dose given <14 days prior to onset ☐ 2nd dose given >14 days prior to onset
Date of 1st dose: _______/ _______/______ MM DD YYYY Date of 2nd dose: ______/ ______/ ______ MM DD YYYY
24. Did the patient receive any influenza vaccine in previous seasons? ☐Yes ☐No ☐Unknown

Submitted By: ____ Phone No.: ( )

Date: _______/ _______/ _______ MM DD YYYY

Email address: ____

Influenza-Associated Pediatric Mortality - Reporting Instructions

This document is to guide state and local health department staff in completing the case report form and the use of the CDC Pediatric Influenza-Associated Death Reporting System found on the Secure Data Network (SDN). In order to report cases within this system, each person who will be entering data from the state or local health department will need a digital certificate for the SDN. Persons with access to the SARS reporting system will automatically have approval to access the Pediatric Influenza-Associated Death Reporting System unless another point of contact for the SDN is determined by the state epidemiologist or other state approval.

I. STATE USE ONLY Section (case report form only)
This section at the top of the form should be used by your state health office to record personal identifiers such as name and address of patient. Do not send this information to the Centers for Disease Control and Prevention (CDC). The web-based reporting system will not have data entry fields for this information.

II. Patient Demographics
1. State – state of residence of patient
States are responsible for reporting their residents, regardless of the location of death. In the event a child dies outside their state of residence, the state where the death occurs should make arrangements to transfer any data regarding the case to the patient's state of residence, who should then report the case to CDC. This is a required field in the reporting system and is automatically populated in the web-based report.
2. County – county of residence of patient
3. State ID – the state assigned unique identifier (required field for reporting).
4. CDC ID – the CDC case ID assigned by the web-based reporting system.
5. Age – The age of the patient at the time of death. Age may be entered as days, months, or years. By definition, all cases should be <18 years old.
6. Date of birth – not required for reporting but can be used to search for cases in the web-based reporting system.
7. Sex
8. Ethnicity
9. Race

III. Death Information
10. Date of illness onset – earliest date of symptom onset associated with influenza illness (required field for reporting).
11. Date of death – (required field for reporting).
12. Was an autopsy performed?
13. Location of death – select answer that best describes the last location where pulse was present. If Other, please specify location in text field.
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IV. Influenza Testing
The purpose of the influenza testing section is to collect information on diagnostic influenza testing. Multiple testing methods may be recorded, and negative results as well as positive results can be entered. It is not necessary to enter all laboratory results obtained during the child's illness or post-mortem. For example, if the patient tested negative by rapid test then positive by viral culture, both tests could be entered. All reported cases are required to have at least one positive diagnostic test for influenza along with a corresponding specimen collection date. Result values are specific to the test type that is listed. The web-based reporting system will require a specimen collection date for every test type entered. Commercial rapid diagnostic test – any commercially available rapid test by any manufacturer. This will include tests that differentiate influenza A from B and those that do not differentiate.
Viral culture – any test results obtained from inoculating cell culture with a specimen obtained from the patient. Specimens can include nasal/pharyngeal swab, etc.
Immunofluorescent antibody (DFA) or (IFA) – Staining of cells from patient specimen.
Specific for influenza virus type A or B.
Enzyme immunoassay (EIA) – often, but not always, synonymous with rapid antigen testing
RT-PCR – any test results obtained by amplifying the genetic material obtained from a patient specimen. Specimens can include nasal/pharyngeal swab, etc.
Immunohistochemistry (IHC) - this method is performed in a limited number of laboratories, and involves immunohistochemical staining to detect influenza viral antigens in tissue specimens. Tracheal and bronchial airway tissues provide the highest yield. States may request CDC to perform this testing in questionable cases.

V. Culture confirmation of INVASIVE bacterial pathogens
14. Was an INVASIVE bacterial infection confirmed by culturing an organism from a specimen collected from a normally sterile site (e.g. blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)? The purpose of this question is to collect data on bacterial infections that may have been complicating factors of the influenza illness and potentially led to death. It is important to include information about bacterial organisms that were only cultured from normally sterile sites, examples of which are given in the question. Cultures
from postmortem specimens should also be included.
i. Select any of the species listed or select other and indicate which species was isolated.
ii. If *Neisseria meningitidis* is isolated, indicate serogroup, if known.

VI. Medical Care
15. Did the patient receive medical care for this illness?
16. If YES*, indicate level(s) of care received (check all that apply): i. An Urgent Care visit should be classified as outpatient.
17. Did the patient require mechanical ventilation? i. Do not include cases in which the patient experienced cardiorespiratory arrest and was intubated during an unsuccessful resuscitative effort.

VII. Clinical Diagnoses and Complications
18. Check all the complications that occurred ***during*** the acute illness.

i. Complications are usually stated on the hospital discharge summary or in the general hospital chart. Additionally, hospital physicians may be able to provide information regarding a patient's hospital course. [do not include suspected diagnoses?]
NONE - If the patient did not have any pre-existing medical conditions, select NONE.
Acute Respiratory Disease Syndrome (ARDS)
Another viral co-infection – specify diagnosis if available.
Bronchiolitis
Croup
Encephalopathy/encephalitis
Other
Pneumonia (Chest X-Ray confirmed)
Reye syndrome
Seizures
Shock
19. Check all medical conditions that existed before the start of the acute illness: i. Previous medical conditions are often listed on the hospital admission note or in the general hospital chart. Additionally, hospital physicians may be able to provide information regarding a patient's previous medical onditions.
NONE - If the patient did not have any medical conditions that existed before the start of the acute illness, select NONE.
Asthma/reactive airway disease
Cardiac disease (specify). Renal disease (specify)
Chronic pulmonary disease (specify) – specify any underlying chronic pulmonary disease that existed before the acute illness, other than asthma.
Cystic fibrosis
Diabetes mellitus, Metabolic disorder (specify) - includes endocine disorders
Hemoglobinopathy (e.g. sickle cell disease) – does not include sickle cell trait.
Immunosuppressive condition (specify) - includes HIV infection, immunosuppressive therapy
Pregnant (specify gestational age in weeks)
History of febrile seizures, Seizure disorder - includes disorders other than febrile seizures
Moderate to severe developmental delay. Neuromuscular disorder (including cerebral palsy)
Other – Use this selection if there is an underlying condition that is not available for selection. Be as specific as possible about the condition.

VIII. Medication and Therapy History
20. Was the patient receiving any of the following therapies prior to illness onset? (check all that apply)
Aspirin or aspirin-containing products
Systemic steroids - taken orally or by injection, does not include inhaled steroid therapy.
Chemotherapy treatment for cancer
Radiation therapy
Any other immunosuppressive therapy

IX. Influenza vaccine history
21. Did the patient receive any influenza vaccine during the current season?
22. If YES*, please specify the type of influenza vaccine received before illness onset: i. Select either the trivalent inactivated vaccine or live attenuated vaccine (nasal spray). If patient received both, select both.
23. If YES*, how many doses did the patient receive and what was the timing of each dose? (Enter dates of vaccination if available)
i. Children receive either one or two doses of influenza vaccine depending on their age. If the child received only 1 dose, then select 1 dose ONLY. If the child received two doses, select 2 doses. Only one of these two selections can be made in the web-based reporting system.
ii. For each selection indicate if the last dose was given more than or equal to 14 days, or less than 14 days, before the patient reported symptoms.
iii. For each selection enter the date or dates of vaccination if available.
24. Did the patient receive any influenza vaccine in previous seasons? - refers to any season in the past

X. Submitting Information
The person submitting the form, their contact phone number, email, and date submitted will be automatically populated in the web-based reporting system with the information corresponding to the person entering the information. The date submitted will be considered the date reported by the web-based system.